Check ____

Cash ____

CLIENT DATA FORM

How many hours did you fast?	_____
Have we tested you before?	**Y N**

SEX: √ ❒ **Female** ❒ **Male** **BIRTH DATE:** ____ -- ____ -- ____
month day year

NAME (Print) _____ _____
LAST name **FIRST name**

ADDRESS (number/street) _____

CITY _____ **STATE** _____ **ZIP**_____ **PHONE** _____

YOUR AGE _____ **YOUR HEIGHT**_____ **YOUR WEIGHT**_____

CURRENT HISTORY	**Circle one**
Do you have a medical provider?	**Y N**
Are you currently using tobacco?	**Y N**
Have you quit tobacco use recently? **How long ago?** _____ **months** _____ **years**	**Y N**
Do you currently do some form of physical activity on a regular basis? (at least 3 times/week)	**Y N**

DIABETES	
Does a parent, grandparent, brother, or sister have diabetes? √ **Check box if unknown** ❒	**Y N**
Do you have diabetes? If yes, do you control diabetes by: **Medicine: Y N Diet: Y N Exercise: Y N**	**Y N**

HEART HEALTH	
Do you take a prescribed cholesterol-lowering medication?	**Y N**
Do you have a history of high blood pressure?	**Y N**
Do you take a prescribed blood pressure medication?	**Y N**
Are you taking herbal or over the counter products for cholesterol or blood pressure?	**Y N**

CONSENT FOR BLOOD SAMPLE:

I consent to having a blood sample drawn for the purpose to determine my blood cholesterol level. The screening will be kept confidential. **UNDER 18 a parent signature is required**

_____ _____ _____
Signature **Parent/Guardian** **Today's Date**

THIS FORM ALSO AVAILABLE ON CDHD WEB SITE:
www.cdhd.idaho.gov

April 2011

WC

_____/_____
BP Reading